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ABSTRACT

A 17-year-old boy presented for treatment with chronic diarrhea that had proven refractory to medical treatment for a period of five years. The problem was sufficiently debilitating to cause highly erratic school attendance. Anamnesis revealed no precipitating event, though it was discovered that the patient's mother was a moderately compensated, chronic schizophrenic who continued to live in the home. The patient appeared to be the focus of family conflicts generated by her condition, and his individuation efforts were thwarted by her needs for constant care and support. The patient's diarrhea was understood from two perspectives. On an intrapsychic level, it was a manifestation of suppressed rage towards the mother for the sacrifice of his autonomy. On a family systems level, it served the function of keeping the patient in the home, and seemed part of a family collusion demanding that someone be available to monitor and care for the mother. A treatment approach was developed, consisting of individual therapy designed to facilitate the ventilation of the patient's anger, and family sessions in order to clarify the nature and limits of his responsibilities to the mother. After several visits, the patient's diarrhea was in complete remission. (Author)

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PSYCHOTHERAPEUTIC TREATMENT OF A
GASTROINTESTINAL DISORDER: INDIVIDUAL AND
FAMILY SYSTEMS PERSPECTIVES.

by

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INTRODUCTION

Modern approaches to psychosomatic phenomena began with Freud, whose principles of psychological causality emerged from the study of hysterical symptoms (Breuer and Freud, 1893). According to Freud, the physical dysfunction in hysterical reactions results from the experience of an unacceptable emotion or impulse that is repressed. The blocked affect achieves somatic expression through unspecified vegetative pathways, thus allowing an indirect discharge of the psychic tension. The recovery and direct discharge of the strangulated affect through hypnotic regression (and later, free association) was found to alleviate hysterical symptoms. This conceptual model remains the crux of psychoanalytic approaches to psychosomatic illness, and the fact that repressed emotion can have deleterious physical effects has gained wide acceptance.

In contrast to this intrapsychic analysis, Minuchin, Rosman, and Baker (1978) have recently examined psychosomatic illness as a family systems phenomena. They present evidence that psychosomatic families interact in a way that reflects a reduced awareness of appropriate boundaries, over protectiveness, a reluctance to face conflict, and an inability to alter the system in response to developmental pressures. In these families, the symptomatic child often diverts attention from more serious problem areas the family is ill-equipped to manage. In this way the patient serves a defensive role in the family system by protecting the members from conflict. Their treatment approach is aimed at reorganizing the family's dysfunctional communication patterns in an effort to make the symptom unnecessary as a conflict reducing mechanism.

Intrapsychic and family systems models are often discussed as though they

were antagonistic and mutually exclusive. However, intrapsychic conflicts are always enacted within a social context; likewise, the social milieu can reinforce and maintain the conflict. Thus, a comprehensive case formulation should consider the regulatory function a symptom serves, both in the intrapsychic economy, and in the larger social system. The following case illustrates the usefulness of these complementary levels of analysis in understanding a psychosomatic case and devising a treatment strategy:

The patient was a 17 year old, caucasian male contacting an out-patient clinic with chronic mucous colitis that had persisted for five years. The problem caused extended absences from school, and long periods of time at home where he was tutored by home bound instructors. Though intense and debilitating during the school year, the colitis was seldom a problem during the summer. Extensive diagnostic testing failed to reveal a physical basis for the problem.

The family consisted of the patient, a 27 year old brother, and the parents whose 30 year marriage remained intact. It was discovered that the mother is a moderately compensated, chronic schizophrenic who has periods of severe regression that involve the whole family in her care and management. Her condition had stabilized since beginning treatment with mellaril 2 years ago. However, she was still tangential and inappropriate in her verbal productions, and suffered from circumscribed delusions. Because of the mother's condition there was a collusion among family members to protect her from strain by tolerating her eccentricities, assuming her domestic responsibilities, and keeping her cloistered in the home.

The alignments in the family consisted of strong attachments between the mother and her two sons, and a father who was quite detached from the family. In recent years, both the patient and his brother had shouldered much of the responsibility for the mother's care, thus allowing the father to become increasingly uninvolved. However, for the patient this responsibility was suffused with intense ambivalence. The mother was extremely infantilizing with the patient, was very solicitous about his physical and emotional well being, and talked to him in a coddling, pampering manner. This invariably aroused the patient's anger, though overt expression of his feelings provoked severe condemnation from the father. Thus, he related to the mother in a sullen passive aggressive fashion, and was constantly struggling to

suppress his hostile feelings. It is important to note that the father had considered institutionalizing the mother several years prior to the onset of the patient's symptoms. The vigorous objections of the older brother prevented this, and both sons are presently committed to keeping the mother in the home.

The identified patient was an attractive and articulate young man with an engaging manner. At the time of the initial interview he had become quite exasperated by physical problem and skeptical that therapy would help. He described himself prior to the onset of the symptoms as an active, adventure seeking child, who socialized easily and enjoyed athletics. However, for the last several years he had been socially isolated and confined to the home. The patient's fantasy life was filled with adventure and autonomous striving, and he bitterly blamed the colitis for his inability to act out these fantasies.

F O R M U L A T I O N

From an intrapsychic perspective it was clear the patient was struggling with separation-individuation conflicts that had failed to achieve an adequate resolution. As the primary target of the mother's infantilizing behavior, his individuation efforts were constantly thwarted, and led to the experience of intense frustration and rage. His periodic angry outbursts toward the mother were reactions to symbolic violations of his autonomy, such as her invasions of his privacy and her intrusive nurturance. These outbursts were invariably followed by guilt and protective concern, and an attempt to suppress his hostile feelings. From a classical psychoanalytic perspective, one would say the patient was binding a tremendous amount of aggressive energy, both his individuation efforts and autonomous strivings, as well as his anger. In this sense, the colitis could be understood as a manifestation of intrapsychic conflicts, and represented blocked energy that achieved a somatic expression.

From a family systems perspective, the mother's condition potentiated the development of the transactional dysfunctions enumerated by Minuchin. Her hyperreactivity to emotional stress and lack of awareness of appropriate

boundaries drew the family into a highly enmeshed interactional style. Relatively minor stresses could exacerbate her condition and cause intense reverberations throughout the system. This led quite naturally to over-protectiveness, conflict avoidance, and a rigid resistance to changes associated with maturational developments and internal stress. When a family is unable to deal with stress in a productive, growth enhancing fashion, somatization offers a way to restablize the system. The symptomatic child protects the family from having to deal with conflictual issues and thereby serves a defensive role.

In this family the patient's colitis served to keep him home with the mother, and saved the other family members the hardship of having to participate more actively in her management. Also, it seemed to reflect an attempt to obstruct the father's efforts to institutionalize the mother by making her indispensable. As long as the patient was ill, the mother could serve a useful role in the family by taking care of him. Thus, the patient was a "sacrificial lamb" who saved the family from more pervasive disruption and conflict by attaching himself symbiotically to the mother. In this way the family colluded in thwarting his individuation efforts in an attempt to maintain emotional homeostasis.

In summary, it appeared that the colitis served an equilibrating function both in the intrapsychic economy and in the family system. On an intrapsychic level it represented the transformation of aggressive energy that could not achieve a more adaptive expression through emotional growth and the development of autonomy. On a family level, it relieved the other family members from more active involvement in the mother's care, and provided the mother with a useful role in the family system.

T R E A T M E N T

It was felt that an exclusive focus on the intrapsychic conflict would be unsuccessful in treating the symptom, since the family colluded in perpetuating the conflict. Likewise, it was felt that efforts to reorganize the family's dysfunctional patterns of communication would have been a long and arduous process, fraught with resistance and painful readjustments the family would be unwilling to undertake. A multilevel formulation allowed a more circumscribed and expedient treatment focus. The therapy dealt exclusively with the patient's separation-individuation conflicts and involved the family only to the extent that their collusion thwarted the patient's individuation efforts. In this way it was felt that the patient's symptoms could be relived, though the family would be allowed to continue their dysfunctional interactional style. The treatment strategy consisted of two simultaneous approaches: 1) individual sessions were held with the patient to facilitate the identification and expression of his feelings of rage, and to encourage his efforts to individuate; 2) family sessions were conducted in order to clarify the nature and limits of the patient's obligation towards the mother.

The treatment in this case was swift and dramatic due to the patient's high level of tension and the pressing need for some form of adaptive reorganization in the family. The patient was first seen individually for three sessions where his feelings of rage were quickly uncovered and related to the stifling relationship with his mother. These feelings were legitimized and encouraged, which led to some useful ventilation of feeling within a permissive therapeutic context. Though there was temporary improvement in his symptoms and he began attending school, he quickly relapsed and was again bedridden with painful colitis attacks. Clearly, the symptom's regulatory function

within the family system needed to be addressed in order to bring about lasting change.

The father-son dyad was chosen as the unit for intervention for several reasons: 1) he was more approachable and less vulnerable than the mother; 2) he appeared to be covertly perpetuating the patient's problem by abdicating responsibility for the mother; and 3) he would likely be left to deal with the consequences if the patient's improvement had a destabilizing effect of the family. It is important to note that the men in the family had never discussed their difficulties in dealing with the mother, and colluded in viewing the patient as intolerant and unsympathetic. Therefore, during this session, the patient's symptoms were repeatedly framed as a sacrifice designed to keep him in the home in order to protect the mother. This challenged the prevailing view of the patient as self-preoccupied, and demonstrated that he was involved, though ambivalently, in the mother's management.

Ultimately, these reframings and a careful pull for affective reactions during the session led to a dramatic confrontation between the patient and his father. The father was quite forceful in his insistence that the patient consider himself alleviated from the exaggerated sense of responsibility he felt towards the mother. He also expressed a strong commitment to avoid institutionalization, and his intention to care for the mother throughout her lifetime. By the end of the session, the father was talking freely of his own feeling of entrapment and frustration, and tearfully implored the patient to avoid this unnecessary sacrifice.

In working through this confrontation in subsequent sessions, it was clear the patient felt his feelings of anger had been legitimized, and that he now free to separate from the family. Over the next several weeks there was a striking surge towards individuation, accompanied by a complete remission

of the colitis symptoms. Initially, the patient described a constant surplus of energy that almost sounded like manic excitement, and he aggressively pursued experiences outside the family that had been sacrificed during his long illness. During this time, he began acting out sexually, staying out all night, and even disappeared for several days, causing the parents great consternation. However, his relationship with his mother improved dramatically, and the family was uniformly impressed by his increasing tolerance and control of his hostile feelings.

Gradually over the next few months the patient's energy began to dissipate and he became more organized and directed in his individuation efforts. He now has a job, plans to earn a G.E.D. certificate, and hopes to begin college in the fall. Throughout this period the patient has remained symptom free, and the family appears to have accommodated comfortably to his increasing independence.

D I S C U S S I O N

It is felt that a multilevel conceptual approach was critical in the formulation of this case. On an intrapsychic level the diarrhea seemed to represent blocked drives and impulses that achieved a somatic expression. Though some argue that hydraulic models of intrapsychic functioning are somewhat antiquated, it is striking that a release of this energy in the form of autonomous strivings was accompanied by a complete remission of symptoms. However, the formulation would be incomplete without an appreciation of the problem at a family systems level. This family was too dysfunctional to deal with conflict in a growth enhancing fashion; therefore, they colluded in suppressing the patient's individuation efforts in order to stabilize the system.

It is also felt that a multilevel conceptualization facilitated treatment. An individually oriented approach would have ignored the family's covert efforts to maintain the conflict. Likewise, attention to the family's dysfunctional patterns of communication would have lost sight of the specific conflict they were attempting to avoid. A multilevel conceptualization provided a circumscribed and expedient treatment focus; namely the patient's separation conflicts and the family's collusion to thwart his individuation.

Certainly, many psychosomatic illnesses are more deeply embedded in the dysfunctional family context, and would prove refractory to such a circumscribed focus. In these cases a more extensive reorganization of communication patterns may be necessary. However, this case illustrates the usefulness of careful conceptualization in devising a treatment strategy, and the possibility of providing symptom relief without pervasive alterations of the family's transactional style.